EXHIBIT A

Excerpted Medical Records of Mendel Epstein

ORANGE REGIONAL MEDICAL CENTER
ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Epstein, Mendel
MRN: 1063420, DOB: [redacted]1945, Sex: M
Adm: 4/16/2020, D/C: 4/22/2020

Consult Notes

Consults signed by Nketiah, Emmanuel, MD at 4/20/2020 2:47 PM Version 1 of 1

Author: Nketiah, Emmanuel, MD Service: Cardiology Author Type: Physician
Filed: 4/20/2020 2:47 PM Date of Service: 4/17/2020 10:22 AM Status: Signed
Editor: Nketiah, Emmanuel, MD (Physician)

Consult Orders
1. Inpatient consult to Cardiology [86690804] ordered by Sayeed, Quais, ResidentDO at 04/16/20 1412

DATE OF CONSULTATION: April 17, 2020

CARDIOLOGY CONSULTATION

REFERRING PHYSICIAN: Ayfer Ekiz, MD

REASON FOR CONSULT: Atrial fibrillation.

HISTORY OF PRESENT ILLNESS: The patient is a 74-year-old male known to me from the office. Briefly, he has a history of essential hypertension, mixed hyperlipidemia, CAD, status post 4-vessel CABG done at Beth Israel Hospital. Of note, the patient's last ischemic evaluation was 4 years ago and at that time the patient underwent a stress test that was felt to be negative. We saw the patient after a syncopal event in the office back in June of 2015. At that time the patient had been on carvedilol and he felt dizzy on it, as a result that was changed to metoprolol without any recurrent events. The plan was for him to undergo a stress test given the low ejection fraction. Unfortunately, due to COVID-19 the stress test never happened.

The patient presented to the hospital with progressive shortness of breath with rest and with exertion. He has shortness of breath with any ambulation. This is associated with a dry cough as well as fevers and chills. The patient was found to be hypoxic in the 80s and was sent to the hospital for further evaluation. Currently the patient tells me he is very short of breath, also has difficulty lying down flat, especially without his CPAP here in the hospital. No edema, no PND.

REVIEW OF SYSTEMS:
Constitutional: Fevers and chills.
HEENT: No difficulty swallowing.
Respiratory: Shortness of breath, cough.
Cardiovascular: Reported edema. No chest pain, no palpitations. GI: No nausea, no vomiting.
GU: No dysuria.
Neuro: No syncopal event.
Review of Systems
All other systems reviewed and are negative.

Past Medical History:

Diagnosis	Date

ORANGE REGIONAL MEDICAL CENTER
ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Epstein, Mendel
MRN: 1063420, DOB: [redacted]1945, Sex: M
Adm: 4/16/2020, D/C: 4/22/2020

Consult Notes (continued)

Consults signed by Nketiah, Emmanuel, MD at 4/20/2020 2:47 PM (continued) Version 1 of 1

- A-fib
- Anxiety
- Blepharitis
- Cataracts, bilateral
- Diabetes mellitus
  type 2
- Hearing loss
- Hyperlipidemia
- Hypertension
- Impacted cerumen of right ear
- Polyneuropathy
- Presbyopia

Past Surgical History:

Procedure	Laterality	Date
• CARDIAC SURGERY		
• CORONARY ARTERY BYPASS GRAFT		

Family History

Problem	Relation	Age of Onset
• Stroke	Mother	
• Heart attack	Mother	
• Hypertension	Mother	

Social History

Socioeconomic History

- Marital status: Single
  - Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Not on file

Social Needs

- Financial resource strain: Not on file
- Food insecurity:
  - Worry: Not on file
  - Inability: Not on file
- Transportation needs:

Consult Notes (continued)

Consults signed by Nketiah, Emmanuel, MD at 4/20/2020 2:47 PM (continued) Version 1 of 1

Medical:	Not on file
Non-medical:	Not on file

Tobacco Use

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used

Substance and Sexual Activity

• Alcohol use:	Not Currently
Frequency:	Never
• Drug use:	Not Currently
• Sexual activity:	Not on file

Lifestyle

• Physical activity:	
Days per week:	Not on file
Minutes per session:	Not on file
• Stress:	Not on file

Relationships

• Social connections:	
Talks on phone:	Not on file
Gets together:	Not on file
Attends religious service:	Not on file
Active member of club or organization:	Not on file
Attends meetings of clubs or organizations:	Not on file
Relationship status:	Not on file
• Intimate partner violence:	
Fear of current or ex partner:	Not on file
Emotionally abused:	Not on file
Physically abused:	Not on file
Forced sexual activity:	Not on file

Other Topics	Concern
• Not on file	

Social History Narrative

- Not on file

Prior to Admission medications

Medication	Sig	Start Date	End Date	Taking?	Authorizing Provider
amlodipine (NORVASC) 10 MG tablet	Take 10 mg by mouth daily.			Yes	Provider, Historical, MD

ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Epstein, Mendel
MRN: 1063420, DOB: [redacted]1945, Sex: M
Adm: 4/16/2020, D/C: 4/22/2020

Consult Notes (continued)

Consults signed by Nketiah, Emmanuel, MD at 4/20/2020 2:47 PM (continued) Version 1 of 1

aspirin 81 MG tablet	Take 81 mg by mouth daily.			Yes	Provider, Historical, MD
atorvastatin (LIPITOR) 40 MG tablet	Take 40 mg by mouth daily.			Yes	Provider, Historical, MD
chlorthalidone (HYGROTEN) 25 MG tablet	Take 25 mg by mouth daily. Indications: 2 tablets daily			Yes	Provider, Historical, MD
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	Take 30 mg by mouth daily.			Yes	Provider, Historical, MD
lisinopril (PRINIVIL,ZESTRIL) 40 MG tablet	Take 40 mg by mouth daily.			Yes	Provider, Historical, MD
meclizine (ANTIVERT) 25 MG tablet	Take 25 mg by mouth 3 (three) times daily as needed for Dizziness (pm).			Yes	Provider, Historical, MD
metformin (GLUCOPHAGE) 850 MG tablet	Take 850 mg by mouth daily.			Yes	Provider, Historical, MD
metoprolol tartrate (LOPRESSOR) 25 MG tablet	Take 0.5 tablets by mouth 2 (two) times daily.	1/9/20	1/8/21	Yes	Hahn, Christina, NP
potassium chloride SA (K-DUR,KLOR-CON) 20 MEQ tablet	Take 1 tablet by mouth daily.	1/9/20	1/8/21	Yes	Hahn, Christina, NP

No Known Allergies

PHYSICAL EXAM:

BP 137/84 (BP Location: Left arm, Patient Position: Sitting) | Pulse 69 | Temp 99.3 °F (37.4 °C) (Oral) | Resp 19 | Ht 5' 9" (1.753 m) | Wt (!) 225 lb (102.1 kg) | SpO2 92% | BMI 33.23 kg/m²

Physical Exam
Constitutional: He is oriented to person, place, and time. No distress.
HENT:
Mouth/Throat: No oropharyngeal exudate.
Neck: No JVD present.
Cardiovascular: Normal rate and regular rhythm.

ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Epstein, Mendel
MRN: 1063420, DOB: [redacted]1945, Sex: M
Adm: 4/16/2020, D/C: 4/22/2020

Consult Notes (continued)

Consults signed by Nketiah, Emmanuel, MD at 4/20/2020 2:47 PM (continued) Version 1 of 1

Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal.
Musculoskeletal: He exhibits no edema.
Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm. He is not diaphoretic.

Lab Results

Component	Value	Date
CKTOTAL	352	04/18/2020
TROPONINI	0.04 (H)	04/18/2020

Lab Results

Component	Value	Date
CREATININE	1.37 (H)	04/20/2020
BUN	41 (H)	04/20/2020
NA	142	04/20/2020
K	3.8	04/20/2020
CL	107	04/20/2020
CO2	26	04/20/2020

Lab Results

Component	Value	Date
WBC	12.4 (H)	04/19/2020
HGB	12.8 (L)	04/19/2020
HCT	39.4 (L)	04/19/2020
MCV	84.2	04/19/2020
PLT	342 (H)	04/19/2020

Lab Results

Component	Value	Date
ALT	30	04/19/2020
AST	35	04/19/2020
ALKPHOS	51	04/19/2020
BILITOT	0.6	04/19/2020

I personally reviewed ecg

LABORATORY AND X-RAY DATA: I personally reviewed the patient's EKG, that showed atrial

ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Consult Notes (continued)

Consults signed by Nketiah, Emmanuel, MD at 4/20/2020 2:47 PM (continued) Version 1 of 1

fibrillation with PVCs, LVH as well as mildly prolonged QTc. On telemetry the patient appears to be in AFib, rate controlled at 80 beats per minute.

ASSESSMENT AND PLAN:

1. Atrial fibrillation appears to be new onset. The patient remains rate controlled. At this point will continue the patient on metoprolol for rate control. Will start the patient on Eliquis 5 twice a day given concomitant Covid and elevated CHADS-VASc score.
2. Shortness of breath, likely COVID-19 infection, unable to exclude CHF given prior low ejection fraction. The COVID-19 test is pending, if negative will proceed with an echo to reassess the ejection fraction.
3. Elevated troponin, likely in the setting of hypoxia, shortness of breath and atrial fibrillation. This is less likely acute thrombotic event. The patient is initiated on Eliquis as above, as a result no heparin is recommended.
4. Stable CAD. Will continue the patient on aspirin and beta blocker.
5. Chronic congestive heart failure with systolic and diastolic dysfunction. The patient appears short of breath, as a result may benefit from gentle diuresis as needed. At this point I would like to continue the patient on lisinopril and Imdur. Would recommend holding chlorthalidone for now given infection as well as increased creatinine.
6. Essential hypertension. Will continue amlodipine and beta blocker. Thank you for the consult.

Emmanuel Nketiah, MD
DATE OF CONSULTATION: April 17, 2020

Signed by Nketiah, Emmanuel, MD on 4/20/2020 2:47 PM

Discharge Summaries

Discharge Summary by Guobadia, Osa, ResidentMD at 4/22/2020 2:26 PM

Author: Guobadia, Osa, ResidentMD Service: Internal Medicine Author Type: Resident
Filed: 4/22/2020 5:19 PM Date of Service: 4/22/2020 2:26 PM Status: Attested
Editor: Guobadia, Osa, ResidentMD (Resident)
Related Notes: Original Note by Guobadia, Osa, ResidentMD (Resident) filed at 4/22/2020 5:18 PM
Cosigner: Purice, Gabriel, MD at 4/23/2020 7:25 AM

Discharge Summary
Orange Regional Medical Center

Mendel Epstein 1063420	**Admit date and time:** 4/16/2020 9:52 AM **Discharge date:** 4/22/2020

ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Epstein, Mendel
MRN: 1063420, DOB: [redacted]1945, Sex: M
Adm: 4/16/2020, D/C: 4/22/2020

Discharge Summaries (continued)

Discharge Summary by Guobadia, Osa, ResidentMD at 4/22/2020 2:26 PM (continued)

74 y.o. 7/6/1945	**Admitting Physician**: Nadia M. Mustafa, MD **Discharge Physician:** Purice, Gabriel, MD

Admission Condition: Poor
Discharged Condition: Stable

Admission Diagnoses:
Hypokalemia [E87.6]
Hypoxia [R09.02]
Elevated troponin [R79.89]
Community acquired bilateral lower lobe pneumonia [J18.1]
Suspected Covid-19 Virus Infection [R68.89]

Discharge Diagnoses:
Active Hospital Problems

Diagnosis

- *COVID-19 virus infection
- New onset atrial fibrillation
- Hypertension
- Type 2 diabetes mellitus, without long-term current use of insulin
- Hyperlipidemia
- Elevated troponin
- Chronic combined systolic and diastolic congestive heart failure
- AKI (acute kidney injury)
- Demand ischemia of myocardium
- OSA on CPAP
- Pneumonia of both lungs due to infectious organism
- Coronary artery disease involving native coronary artery of native heart with angina pectoris

Indication for Admission and Hospital Course Significant Findings:
Mendel Epstein is a 74 y.o. male with a PMH of CHF, combined systolic & diastolic dysfunction, CAD s/p CABG, HTN, HLD, OSA (on CPAP), DM 2 w/neuropathy who presented on 4/16 from Otisville Correctional Facility for shortness of breath and dry cough. Patient was found to be hypoxic and reportedly had exposure to a Covid positive patient at the facility. He was tested for Covid-19 and brought in for hypoxia. He was admitted for acute hypoxic respiratory failure 2/2 COVID pneumonia. Test came back positive on 4/17/2020. ED w/u was significant for AKI, new-onset afib, acute hyponatremia, leukocytosis, Hypokalemia and U/S of bilateral lower that ruled out DVT.

For the acute hypoxic respiratory failure 2/2 COVID-19 pneumonia, he was initially started on antibiotics based on suspicious imaging findings. They were discontinued after COVID was confirmed and pneumonia ruled out. Steroids were continued till day of discharge. He received a 6-day course

ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Epstein, Mendel
MRN: 1063420, DOB: [redacted]1945, Sex: M
Adm: 4/16/2020, D/C: 4/22/2020

Discharge Summaries (continued)

Discharge Summary by Guobadia, Osa, ResidentMD at 4/22/2020 2:26 PM (continued)

of 100 mg prednisone and was discharged on a steroid taper. Oxygen requirements progressively decreased and on day of discharge, he was on room air, with oxygen saturation > 92%.

On admission, he was diagnosed with new-onset atrial fibrillation. With CHA_2DS_2-VASc score of, he was started on Eliquis 5 mg bid daily and his PTA lopressor 12.5 mg bid daily. Dr. Nketiah was consulted and followed patient during his admission. He will follow patient on discharge for further workup.

Hyponatremia, hypokalemia, and AKI resolved prior to discharge. His prior to admission lisinopril was held due to his present ing AKI. It was restarted when patent's blood pressure became >170, after touching base with Dr. Nketiah.
For his chronic conditions, DM, essential HTN and CHF combined diastolic and systolic, we continued his Imdur, lisinopril and Norvasc. He was placed on ISS and he blood glucose was controlled during his admission.

Hospital course was complicated by episodes of asymptomatic bradycardia at nights when he was asleep.
On day of discharge, he was deemed medically stable for discharge. He was discharged back to Otisville Correctional Facility.

Consults

Consulting Physicians

Provider	Role	Specialty	Primary office phone
Nketiah, Emmanuel, MD	Consulting Physician	Cardiology	845-333-7575

Discharge Exam

Temp: [98 °F (36.7 °C)-98.4 °F (36.9 °C)] 98 °F (36.7 °C)
Heart Rate: [70-93] 89
Resp: [20] 20
BP: (142-173)/(76-88) 172/79
Temp (24hrs), Avg:98.2 °F (36.8 °C), Min:98 °F (36.7 °C), Max:98.4 °F (36.9 °C)

SpO2: 94 %

Body mass index is 33.23 kg/m².

Intake/Output Summary (Last 24 hours) at 4/22/2020 1427
Last data filed at 4/22/2020 1040

	Gross per 24 hour
Intake	920 ml
Output	—
Net	**920 ml**

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No

ORANGE REGIONAL MEDICAL CENTER
707 EAST MAIN STREET
MIDDLETOWN NY 10940-2650

Epstein, Mendel
MRN: 1063420, DOB: [redacted]1945, Sex: M
Adm: 4/16/2020, D/C: 4/22/2020

Discharge Summaries (continued)

Discharge Summary by Guobadia, Osa, ResidentMD at 4/22/2020 2:26 PM (continued)

distress.
Eyes: Conjunctivae are normal. No scleral icterus.
Neck: No JVD present. No tracheal deviation present.
Cardiovascular: Normal rate. An irregularly irregular rhythm present.
Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. He has no wheezes. He has no rales. He exhibits no tenderness.
Abdominal: Soft. Normal appearance and bowel sounds are normal. He exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.
Musculoskeletal: He exhibits no edema or deformity.
Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm and dry. He is not diaphoretic.
Psychiatric: He has a normal mood and affect. His speech is normal and behavior is normal.
Nursing note and vitals reviewed.

Discharge Labs and Imaging

Recent Labs

Lab	04/16/20 1009	04/17/20 0547		04/19/20 0527	04/21/20 0559	04/22/20 0514
WBC	6.4	5.9	< >	12.4*	13.5*	14.9*
HGB	12.8*	12.4*	< >	12.8*	12.6*	12.6*
HCT	39.4*	37.4*	< >	39.4*	39.9*	40.4
PLT	224	247	< >	342*	390*	399*
NEUTOPHIL PCT	79.3*	70.1	--	--	--	88.6*
MONO PCT	6.7	6.8	--	--	--	4.3

< > = values in this interval not displayed.

Recent Labs

Lab	04/16/20 1009	04/17/20 0547
APTT	28.1	28.7
INR	1.08	1.08

Recent Labs

Lab	04/16/20 1009		04/16/20 1610		04/17/20 0547	04/17/20 1228	04/18/20 0624

Recent Labs

Lab	04/17/20 0547	04/18/20 0624	04/19/20 0527	04/20/20 0518	04/21/20 0559	04/22/20 0514
NA	136	138	141	142	143	141
K	3.2*	3.7	3.4*	3.8	4.1	4.2
CL	98*	101	105	107	107	108
CO2	25	26	26	26	28	23
BUN	40*	41*	47*	41*	37*	38*
CREATININE	1.61*	1.43*	1.48*	1.37*	1.30*	1.35*
CALCIUM	8.4*	8.4*	8.8	8.6	8.7	8.6
LABALBU	2.7*	2.5*	2.7*	--	--	--
PROT	6.6	6.1*	6.4	--	--	--
BILITOT	0.8	0.6	0.6	--	--	--
ALKPHOS	54	50	51	--	--	--
ALT	30	29	30	--	--	--
AST	60*	41	35	--	--	--

EXHIBIT B

Certification of
Dr. Robert Goldstein

Supplemental Declaration for Mendel Epstein

COVID-19 April 24, 2020

I, Robert Goldstein, declare as follows:

1. My name is Dr. Robert Goldstein. I am board-certified in clinical cardiovascular disease, as well as clinical cardiac electrophysiology by the American Board of Internal Medicine (ABIM). I served as director of the Cardiac Device Clinic at University Hospitals Case Western Reserve for over a decade. Currently, I am the director of cardiac electrophysiology at Lake Health Medical Center. I have twenty years of experience in treating cardiovascular disease.

2. I prepared a letter dated April 3, 2020 with regards to Mr. Mendel Epstein's medical conditions and the risks of COVID-19. Additional developments, both to Mr. Epstein's health and the world's general knowledge of COVID-19, have occurred since the date of such letter which necessitated this supplementary letter.

3. I have reviewed the following items which were provided to me by Mr. Epstein's counsel: medical records of Mr. Epstein's hospitalization from Orange County Regional Medical Center from April 16, 2020 - April 22, 2020.

4. Mr. Epstein was hospitalized on Thursday, April 16, 2020. He was brought to the hospital by emergency medical services to the emergency room with complaints of coughing, fever, shortness of breath, rapid breathing and low oxygen saturation. Records indicate that his symptoms had started several days earlier. The results of the COVID-19 tests drawn in the correctional facility were not expected back for several days. As indicated in my initial letter, his previous medical history was significant for hypertension, diabetes and previous cardiac bypass surgery.

5. The medical report from his hospitalization contains a laboratory finding in the emergency room of acute renal failure probably secondary to dehydration, and hypokalemia. An EKG was changed relative to the most recent EKG, and his cardiac enzymes were elevated. A chest X-ray showed patchy infiltrates indicative of COVID-19. He was diagnosed with pneumonia in both lungs as a result of infection. During his admission, he developed new-onset cardiac arrythmia atrial fibrillation which, in addition to the current EKG and elevated cardiac enzymes, indicates Mr. Epstein may have suffered a heart attack. Based on these records, Mr. Epstein is overdue for a stress test and requires significant additional workup to rule out current additional cardiac involvement in his symptoms. Unfortunately, a stress test to find out the true extent of his cardiac issues is impossible at present time, as acknowledged by his treating facility on page 57 of his medical records.

6. Mr. Epstein was discharged on Wednesday, April 22, 2020 and was returned to FCI Otisville CAMP to be placed in isolation for 14 days, without contact to his family and little oversight.

7. This is completely contraindicated for the health and safety of Mr. Epstein on many counts. First, when patients are discharged from hospitals, some have showed fever, positive tests and other symptoms thereafter. A short stay in a hospital is generally not indicative of one's recovery from the virus. On the contrary, most patients sent home from the hospital are sent to a clean, germ-free location, an optimal environment necessary to ensure the body fully recovers. Second, patients that are discharged, especially ones given oxygen treatment while hospitalized, are generally provided individualized treatment protocols upon their return to their respective home. Sending

Mr. Epstein back to Otisville, where he initially fell ill, is unlikely to provide him either of these solutions, and can exacerbate the long-standing effects of COVID-19.

8. At discharge, after multiple days of IV fluids, Mr. Epstein's kidney function markers still show elevated BUN and creatinine, suggestive of acute renal failure.

9. There are recent studies that have indicated that there is a high incident of blood clotting issues in COVID-19 patients. Mr. Epstein's family history includes stroke and cardiovascular disease. Based on his own history of cardiovascular disease necessitating his multiple bypass surgery, including congestive heart failure, his new onset atrial fibrillation noted on page 63 of his medical records and other findings related to his COVID-19 diagnosis, Mr. Epstein is high-risk for a serious stroke. Without necessary care and constant monitoring, a symptom of stroke may easily be missed.

10. Further, the New York State Health Commissioner issued a do not resuscitate order that was put out by the Bureau of Emergency Medical Service. The Commissioner rescinded the order a short while later. These are contradictory messages to health providers in New York, and there is grave concern these type of messages will continue. This is especially concerning for an inmate who does not have a family member advocating for their health.

11. There is evidence that this virus can be contracted more than once and that the virus stays with individuals for up to thirty days. Returning Mr. Epstein to the source of his contagion is not recommended even if he in isolation for the multitude of reasons set forth herein.

12. The Director for the Center for Disease Control and Prevention has issued a warning about the possibility of an additional fall outbreak of COVID-19. Mr. Epstein should not be in a prison, which have long been notorious incubators for disease and are commonly referred to as a "petri dish for infection."

13. Due to his underlying health conditions, Mr. Epstein cannot be treated with the drug treatments currently being offered to COVID-19 patients. Mr. Epstein suffers from underlying conditions that place him in the highest risk of serious illness or death. Published on April 23, 2020, a first-of-its-kind case study covering 5,700 patients hospitalized with Covid-19 in the New York City area found that the most common comorbidities were those from which Mr. Epstein suffers, including hypertension and diabetes. Among the 2,634 patients who were discharged or had died at the study end point, during hospitalization 14.2% were treated in the ICU, 12.2% received invasive mechanical ventilation, and 21% died. The mortality rate for those in the 65-or-older age group who did not receive mechanical ventilation was 26.6% and for the same cohort who received ventilation it was 97.2%.

14. At this stage, this is a new virus with new information coming out daily. There are no studies regarding long-term immunity against COVID-19. In addition to the negative long-term impact of his continually deteriorating cardiac disease, he may also suffer from pulmonary, renal, and other system failures, as commonly seen in COVID-19 patients. As noted, there is some indication that COVID-19 has already affected these organ systems in Mr. Epstein, as evidenced by his hospital laboratory results and abnormal chest X-rays. There has been no indication that the COVID-19 infection in Mr. Epstein has been resolved.

15. Medical research also indicates that older individuals who have survived COVID-19 may not develop an immunity that will protect them, should they ultimately be exposed to the virus again.

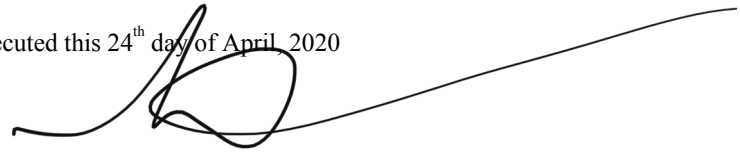
16. Further, considering that prior imaging evidenced that Mr. Epstein has a questionable mass on his kidney and that upon discharge from the hospital his blood work is suggestive of acute renal failure, concern remains for the possibility of complete renal failure.

17. It is my opinion that in order to ensure the safety and well-being of Mr. Epstein, he should not be in isolation without medical care or incarcerated in an environment where germs, diseases and the virus cannot be controlled, particularly at a facility where multiple inmates have already tested positive. There is a high rate of concern his health will deteriorate in the coming weeks due to his contraction of COVID-19. He is at significant risk for relapse and in addition to relapsing may contract a different strain of the virus. There remains no cure and no vaccine.

18. In light of Mendel Epstein's medical history, current state, and developments in the world, I urge the Court even more strongly than I did in my initial certification: Mr. Epstein should be returned to his home, where he can receive the necessary medical care in a proper environment to ensure he does not contract the disease again and can fully recover. Each day Mr. Epstein remains at Otisville increases his chance of succumbing to this awful, deadly disease.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 24th day of April, 2020



_____

Robert Goldstein, MD FHRS
Director of Cardiac Electrophysiology
Lake Health Medical Center
Willoughby, OH

EXHIBIT C

Scientific Brief by the World Health Organization on "Immunity Passports"

World Health Organization

"Immunity passports" in the context of COVID-19

Scientific Brief

24 April 2020

WHO has published guidance on adjusting public health and social measures for the next phase of the COVID-19 response.[1] Some governments have suggested that the detection of antibodies to the SARS-CoV-2, the virus that causes COVID-19, could serve as the basis for an "immunity passport" or "risk-free certificate" that would enable individuals to travel or to return to work assuming that they are protected against re-infection. There is currently no evidence that people who have recovered from COVID-19 and have antibodies are protected from a second infection.

The measurement of antibodies specific to COVID-19

The development of immunity to a pathogen through natural infection is a multi-step process that typically takes place over 1-2 weeks. The body responds to a viral infection immediately with a non-specific innate response in which macrophages, neutrophils, and dendritic cells slow the progress of virus and may even prevent it from causing symptoms. This non-specific response is followed by an adaptive response where the body makes antibodies that specifically bind to the virus. These antibodies are proteins called immunoglobulins. The body also makes T-cells that recognize and eliminate other cells infected with the virus. This is called cellular immunity. This combined adaptive response may clear the virus from the body, and if the response is strong enough, may prevent progression to severe illness or re-infection by the same virus. This process is often measured by the presence of antibodies in blood.

WHO continues to review the evidence on antibody responses to SARS-CoV-2 infection.[2-17] Most of these studies show that people who have recovered from infection have antibodies to the virus. However, some of these people have very low levels of neutralizing antibodies in their blood,[4] suggesting that cellular immunity may also be critical for recovery. As of 24 April 2020, no study has evaluated whether the presence of antibodies to SARS-CoV-2 confers immunity to subsequent infection by this virus in humans.

Laboratory tests that detect antibodies to SARS-CoV-2 in people, including rapid immunodiagnostic tests, need further validation to determine their accuracy and reliability. Inaccurate immunodiagnostic tests may falsely categorize people in two ways. The first is that they may falsely label people who have been infected as negative, and the second is that people who have not been infected are falsely labelled as positive. Both errors have serious consequences and will affect control efforts. These tests also need to accurately distinguish between past infections from SARS-CoV-2 and those caused by the known set of six human coronaviruses. Four of these viruses cause the common cold and circulate widely. The remaining two are the viruses that cause Middle East Respiratory Syndrome and Severe Acute Respiratory Syndrome. People infected by any one of these viruses may produce antibodies that cross-react with antibodies produced in response to infection with SARS-CoV-2.

Many countries are now testing for SARS-CoV-2 antibodies at the population level or in specific groups, such as health workers, close contacts of known cases, or within households.[21] WHO supports these studies, as they are critical for understanding the extent of – and risk factors associated with – infection. These studies will provide data on the percentage of people with detectable COVID-19 antibodies, but most are not designed to determine whether those people are immune to secondary infections.

Other considerations

At this point in the pandemic, there is not enough evidence about the effectiveness of antibody-mediated immunity to guarantee the accuracy of an "immunity passport" or "risk-free certificate." People who assume that they are immune to a second infection because they have received a positive test result may ignore public health advice. The use of such certificates may therefore increase the risks of continued transmission. As

new evidence becomes available, WHO will update this scientific brief.

References

1. Considerations in adjusting public health and social measures in the context of COVID-19. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/critical-preparedness-readiness-and-response-actions-for-covid-19
2. Wölfel R, Corman VM, Guggemos W, et al. Virological assessment of hospitalized patients with COVID-2019. Nature 2020.
3. To KK, Tsang OT, Leung WS, et al. Temporal profiles of viral load in posterior oropharyngeal saliva samples and serum antibody responses during infection by SARS-CoV-2: an observational cohort study. Lancet Infect Dis. 2020 Mar 23. pii: S1473-3099(20)30196-1. doi: 10.1016/S1473-3099(20)30196-1.
4. Wu F, Wang A, Liu M, et al. Neutralizing antibody responses to SARS-CoV-2 in a COVID-19 recovered patient cohort and their implications. medRxiv 2020: 2020.03.30.20047365.
5. Ju B, Zhang Q, Ge X, et al. Potent human neutralizing antibodies elicited by SARS-CoV-2 infection. Biorxiv 2020: 2020.03.21.990770.
6. Poh CM, Carissimo G, Wang B, et al. Potent neutralizing antibodies in the sera of convalescent COVID-19 patients are directed against conserved linear epitopes on the SARS-CoV-2 spike protein. Biorxiv 2020: 2020.03.30.015461.
7. Zhang W, Du R, Li B, Zheng X, et al. Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes. Emerg Microbes Infect. 2020 Feb 17; 9(1):386-389. doi: 10.1080/22221751.2020.1729071.
8. Grzelak L, Temmam L, Planchais C, et al. SARS-CoV-2 serological analysis of COVID-19 hospitalized patients, pauci-symptomatic individuals and blood donors. medRxiv 2020 (submitted 17 April 2020).
9. Amanat F, Nguyen T, Chromikova V, et al. A serological assay to detect SARS-CoV-2 seroconversion in humans. medRxiv 2020: 2020.03.17.20037713.
10. Okba NMA, Müller MA, Li W, et al. Severe acute respiratory syndrome coronavirus 2−specific antibody responses in coronavirus disease 2019 patients. Emerg Infect Dis. 2020 doi: 10.3201/eid2607.200841
11. Zhao J, Yuan Q, Wang H, et al. Antibody responses to SARS-CoV-2 in patients of novel coronavirus disease 2019. Clin Infect Dis. 2020 doi: 10.1093/cid/ciaa344
12. Guo L, Ren L, Yang S, et al. Profiling Early Humoral Response to Diagnose Novel Coronavirus Disease (COVID-19). Clin Infect Dis. 2020 Mar 21. doi: 10.1093/cid/ciaa310.
13. Liu Y, Liu Y, Diao B, Ren Feifei, et al. Diagnostic indexes of a rapid IgG/IgM combined antibody test for SARS-CoV-2. medRxiv 2020; doi: 10.1101/2020.03.26.20044883
14. Zhang P, Gao Q, Wang T, Ke Y, et al. Evaluation of recombinant nucleocapsid and spie protein serological diagnosis of novel coronavirus disease 2019 (COVID-19). medRxiv. 2020; doi: 10.1101/2020.03.17.20036954
15. Pan Y, Li X, Yang G, Fan J, et al. Serological immunochromatographic approach in diagnosis with SARS-CoV-2 infected COVID-19 patients. medRxiv. 2020; doi: 10.1101/2020.03.13.20035428
16. Li Z, Yi Y, Luo X, Xion N, et al. Development and clinical application of a rapid IgM-IgG combined antibody test for SARS-CoV-2 infection diagnosis. J Med Virol. 2020 Feb 27. doi: 10.1002/jmv.25727.
17. Li R, Pei S, Chen B, et al. Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SARS-CoV2). Science 2020.
18. Lou B, Li T, Zheng S, Su Y, Li Z, Liu W, et al. Serology characteristics of SARS-CoV-2 infection since the exposure and post symptoms onset. medRxiv 2020; doi: 10.1101/2020.03.23.20041707
19. Lin D, Liu L, Zhang M, Hu Y, et al. Evaluation of serological tests in the diagnosis of 2019 novel coronavirus (SARS-CoV-2) infections during the COVID-19 outbreak. medRxiv 2020. doi: 10.1101/2020.03.27.20045153
20. Liu W, Liu L, Kou G, Zheng Y, et al. Evaluation of nucleocapsid and spike protein-based ELISAs for detecting antibodies against SARS-CoV-2. medxriv [Internet]. 2020; Available from: https://doi.org/10.1101/2020.03.16.20035014 medRxiv preprint
21. Unity Studies: Early Investigation Protocols https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/early-investigations

WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue an update. Otherwise, this scientific brief will expire 1 year after the date of publication.

Want to read more?

More on COVID-19

EXHIBIT D

Bureau of Prisons April 22, 2020 Memorandum

U.S. Department of Justice
Memorandum
Federal Bureau of Prisons

Correctional Programs Division

Central Office
320 First Street, N.W.
Washington, DC 20534

April 22, 2020

MEMORANDUM FOR CHIEF EXECUTIVE OFFICERS

FROM: Andre Matevousian, Acting Assistant Director
Correctional Programs Division

HUGH HURWITZ Digitally signed by HUGH HURWITZ
Date: 2020.04.22 14:17:15 -04'00'
Hugh J. Hurwitz, Assistant Director
Reentry Services Division

SUBJECT: Home Confinement

In an effort to protect the health and safety of staff and inmates during the COVID-19 pandemic, it has become imperative to review at-risk inmates for placement on home confinement. This memorandum provides additional guidance and direction and rescinds the memorandum dated April 3, 2020.

It should be noted that for public safety reasons, in accordance with the March 26, 2020, memorandum from the Attorney General, and to ensure BOP is deploying its limited resources in the most effective manner, the BOP is currently assessing the following factors to ensure inmates are suitable for home confinement:

- reviewing the inmate's institutional discipline history for the last twelve months;
- ensuring the inmate has a verifiable release plan;
- verifying the inmate's primary or prior offense history does not include violence, a sex offense, or terrorism related;
- confirming the inmate does not have a current detainer;
- reviewing the security level of the facility currently housing the inmate, with priority given to inmates residing in Low and Minimum security facilities;
- reviewing the inmate's score under PATTERN, with inmates who have anything above a minimum score not receiving priority treatment;

- and reviewing the age and vulnerability of the inmate to COVID-19, in accordance with the CDC guidelines.

In addition, and in order to prioritize its limited resources, BOP has generally prioritized for home confinement those inmates who served a certain portion of their sentences, or who only have a relatively short amount of time remaining on those sentences. While these priority factors are subject to deviation in the BOP's discretion in certain circumstances and are subject to revision as the situation progresses, at this time, the BOP is prioritizing for consideration those inmates who either:

- have served 50% or more of their sentences,
- or have 18 months or less remaining on their sentences and have served 25% or more of their sentences.

Additionally, pregnant inmates should be considered for viability of placement in a community program to include Mothers and Infants Together (MINT) programs and home confinement.

All inmates must be reviewed by the SIS Department at the referring facility to determine if the inmate has engaged in violent or gang-related activity in prison. Additionally, inmates must have maintained clear conduct for the past 12 months to be eligible.

Referrals must be made based on appropriateness for home confinement. Consideration should be given to whether the inmate has demonstrated a verifiable reentry plan that will prevent recidivism and maximize public safety, including verification that the conditions which the inmate would be confined upon release would present a lower risk of contracting COVID-19 than the inmate would face in his or her BOP facility.

All referrals should clearly document the review of the following:

- Unit Team staff will screen each inmate identified to determine if they have a viable release residence and ask questions specific to:
  - Specific type of release residence (House/Apt/Group home, etc.),
  - Who will the inmate live with,
  - Any health concerns of individuals in the residence,
  - Contact phone numbers should he/she be placed on home confinement,
  - Transportation plan as to how the inmate will be transferred to the home confinement location.

All the above information must be clearly documented on the referral for home confinement prior to submission to the RRM Office.

Inmates determined to have a viable release residence will be screened by Health Services and a determination made as to if the inmate requires frequent and on-going medical care within the next 90 days. If frequent and on-going medical care is required, then:

- Health Services staff will coordinate with Naphcare and RRMBs Health Services Specialists to determine if the inmate's medical needs can be met in the community at this time. Naphcare will set up follow-up care prior to the inmate's transfer. An inmate must transfer with AT LEAST 90 days of any prescribed medications.
- If the inmate's medical needs cannot be met in the community at this time, the inmate will remain at the BOP facility.
- If the inmate does not require frequent and on-going medical care, a referral to the community will be processed.
- All the above information must be clearly documented on the referral for home confinement prior to submission to the RRM Office.

Once an inmate is referred for home confinement due to the COVID-19 pandemic, the Case Management Activity (CMA) assignment **CV-COM-REF** should be loaded in SENTRY.

If the Warden determines there is a need to refer an inmate for placement in the community due to risk factors, or as a population management strategy during the pandemic; however, the inmate does not meet the above listed criteria, a packet should be forwarded to the Correctional Programs Division for further review. Packets should be sent to BOP-CPD/Assistant Director from the Warden's general mailbox.

Case Management Coordinators must track all inmates determined to be ineligible for home confinement or the Elderly Offender Pilot Program and enter the appropriate denial code in SENTRY. Reports outlining reason for denial must be reported to BOP-CPD/Unit Management on a weekly basis by Monday at 2:00 p.m. EST.

If an inmate does not currently qualify for home confinement under BOP criteria, they should be reviewed for placement in a

Residential Reentry Center and for home confinement at a later date, in accordance with applicable laws and BOP policies.

If you have any questions, please contact David Brewer, Acting Senior Deputy Assistant Director, Correctional Programs Division, at (202)353-3638 or Alix McLearen, Senior Deputy Assistant Director, Reentry Services Division, at (202)514-4919.

EXHIBIT E

Mendel Epstein Individualized Reentry Plan – Program Review (Inmate Copy)

Individualized Reentry Plan - Program Review (Inmate Copy)

SEQUENCE: 01856747

Dept. of Justice / Federal Bureau of Prisons

Team Date: 02-11-2020

Plan is for inmate: EPSTEIN, MENDEL 65960-050

Facility:	OTV OTISVILLE FCI	Proj. Rel. Date:	01-07-2025
Name:	EPSTEIN, MENDEL	Proj. Rel. Mthd:	GCT REL
Register No.:	65960-050	DNA Status:	PHL05652 / 10-15-2013
Age:	74		
Date of Birth:	[redacted]1945		

Detainers

Detaining Agency	Remarks

NO DETAINER

Current Work Assignments

Facl	Assignment	Description	Start
OTV	CHAPELCAMP	CAMP CHAPEL WORKER	01-09-2020

Current Education Information

Facl	Assignment	Description	Start
OTV	ESL HAS	ENGLISH PROFICIENT	06-02-2016
OTV	GED HAS	COMPLETED GED OR HS DIPLOMA	08-25-2016

Education Courses

SubFacl	Action	Description	Start	Stop
OTV SCP	C	DTRM DOING TIME W/ RIGHT MIND	03-12-2019	04-30-2019
OTV SCP	C	NUTRITION SEMINAR ON FAST FOOD	09-19-2019	09-19-2019

Discipline History (Last 6 months)

Hearing Date	Prohibited Acts

*** NO INCIDENT REPORTS FOUND IN LAST 6 MONTHS ***

Current Care Assignments

Assignment	Description	Start
CARE1-MH	CARE1-MENTAL HEALTH	05-03-2016
CARE2	STABLE, CHRONIC CARE	09-21-2016

Current Medical Duty Status Assignments

Assignment	Description	Start
HGT RESTR	NO LADDERS/NO UPPER BUNK	07-25-2016
LOWER BUNK	LOWER BUNK REQUIRED	06-03-2019
NO F/S	NO FOOD SERVICE WORK	07-25-2016
NO PAPER	NO PAPER MEDICAL RECORD	05-03-2016
REG DUTY W	REGULAR DUTY W/MED RESTRICTION	07-25-2016
SOFT SHOES	SOFT SHOES ONLY	07-25-2016
STAND RSTR	NO PROLONGED STANDING	07-25-2016
WGT 15 LB	WEIGHT-NO LIFTING OVER 15 LBS	07-25-2016

Current Drug Assignments

Assignment	Description	Start
ED COMP	DRUG EDUCATION COMPLETE	08-13-2019

FRP Details

Individualized Reentry Plan - Program Review (Inmate Copy)

SEQUENCE: 01856747

Dept. of Justice / Federal Bureau of Prisons

Team Date: 02-11-2020

Plan is for inmate: EPSTEIN, MENDEL 65960-050

Most Recent Payment Plan

Trust Fund Deposits - Past 6 months: $2,161.00 Payments commensurate ? N/A

New Payment Plan: ** No data **

Progress since last review

Assigned as a chapel orderly. FRP complete.

Completed DTRM, PMA (June 2019), Drug Ed (August 2019), the Nutrition Seminar, and the Victim Impact 5 week program in Feb 2020. Programs he was previously interested in were not offered during this review period.

Next Program Review Goals

Complete the 16 week Victim Impact program by 08-2020.

He advises he is enrolled in the Non Res Drug Ed program. Complete by next review.

Long Term Goals

Complete a parenting program by 02-2021.

RRC/HC Placement

Consideration has been given for Five Factor Review (Second Chance Act):
- Facility Resources
- Offense
- Prisoner
- Court Statement
- Sentencing Commission

PRD 2025. No minor children. Eligible for Direct Home Confinement placement through the Elderly Offender component of the First Step Act on 12/23/2022.

Comments

Has medical conditions which limit the types of institutional jobs he can have.

Eligible for Direct Home Confinement placement through the Elderly Offender component of the First Step Act on 12/23/2022.

Does not have original license, SS card or birth certificate but had copies of license and birth certificate mailed in to Camp Unit Team.

Is there documentation in the PSR of any of the following?
Any history of Bankruptcy
No bank account
No assets nor liabilities noted in PSR
Debts noted in Credit Report or other sources
Tax Liabilities/back taxes
Unpaid alimony/child support
Other indications of lack of financial management skills (specify)

YES _____ NO ____X___